

**MEDICAL BOARD OF CALIFORNIA**

LICENSING PROGRAM
 1426 Howe Avenue, Suite 54
 Sacramento, CA 95825-3236
 (916) 263-2382 FAX (916) 263-2567
www.medbd.ca.gov



APPLICATION TO RESTORE LICENSE TO FULL ACTIVE STATUS FROM INACTIVE OR FEE EXEMPT STATUS <i>Please print or type. Illegible applications will be returned.</i>		FOR OFFICE USE ONLY Fee Paid: _____ Receipt No.: _____ Date Cashiered: _____ Cashier's Intl: _____ Date Approved: _____ Date Denied: _____ Enforcement Approval: _____ Yes _____ No Date: _____	
Name (first, middle, last):			
Address: Is this address currently on file with the Medical Board as your official address of record? If not, complete reverse.			
Telephone Number: FAX Number (if applicable):		Telephone () FAX ()	
Current status of your license: (Check ✓ one box only.)	<input type="checkbox"/> Retirement (see Part 1 below)	<input type="checkbox"/> Inactive (see Part 4 on reverse)	
	<input type="checkbox"/> Military Service (see Part 2 below)	<input type="checkbox"/> Disabled (see Part 5 on reverse)	
	<input type="checkbox"/> Voluntary Services (see Part 3 below)		
Social Security Number:			
California Medical License Number:			
Part 1. RETIRED STATUS. Please provide all information requested below.			
Have you been granted a continuing medical education (CME) waiver?		<input type="checkbox"/> No	<input type="checkbox"/> Yes If yes, enter year: _____
A renewal fee is required to restore your license. If your license is delinquent at the time of application you are required to submit payment of any accrued renewal, delinquent and penalty fees.			
Part 2. MILITARY STATUS. Please provide all information requested below.			
If you currently hold a "military" license, a renewal fee is required if you have been discharged from full-time active service or you are still in the military and are canceling your "military" license to restore your license to "active" status. You will also be required to submit payment of any accrued renewal, delinquent and penalty fees if your license is currently delinquent or it has been more than 60 days since your discharge from active service and you have not paid your renewal fees.			
If you checked "Military", please indicate which branch of service. (Check ✓ one box only.)	<input type="checkbox"/> Air Force	<input type="checkbox"/> Army	
	<input type="checkbox"/> Marines	<input type="checkbox"/> Navy	
	<input type="checkbox"/> U. S. Public Health Service		
Have you been granted a CME waiver?		<input type="checkbox"/> No	<input type="checkbox"/> Yes If yes, enter year: _____
Are you still in the Military?		<input type="checkbox"/> No	<input type="checkbox"/> Yes If yes, (complete shaded area below)
Type of service:	<input type="checkbox"/> Active Service/Full-time Training		
Dates of Service or Training:	From: _____	To: _____	
Expected date of Discharge:	_____		
Part 3. VOLUNTARY SERVICES			
To restore your license to "Active" status you must document completion of 50 hours of CME within the past two years. The documentation of these hours MUST be submitted with this application. A renewal fee is required to restore your license. If your license is delinquent at the time of application you are required to submit payment of any accrued renewal, delinquent and penalty fees.			

Part 4. INACTIVE STATUS

To restore your license to "Active" status you must document completion of 50 hours of Continuing Medical Education (CME) within the past two years. The documentation of these hours MUST be submitted with this application.

Part 5. DISABLED STATUS. *Please provide all information requested below.*

Have you been granted a continuing medical education (CME) waiver by the Board?

No

Yes

If yes, enter year.

NOTE TO ATTENDING PHYSICIAN: If "Disabled" was checked on this application, the applicant previously submitted an application for "Disabled" status to the Medical Board of California, which was approved. The applicant documented the inability to practice medicine due to a disability or illness. The applicant is now requesting to be removed from "Disabled" status and to be permitted to practice medicine. Under State law, the applicant must establish to the satisfaction of the Board that the illness or disability no longer exists or does not affect the applicant's ability to practice medicine safely. As the applicant's attending physician, please provide the information requested below.

The Following Must Be Completed By Your Attending Physician:

Approximate date illness began: _____ Duration of illness: Temporary _____ Permanent _____

If "temporary", approximate date the applicant will be able to return to practicing medicine: _____

Is the applicant restricted or limited in any activities? (Check (✓) one) Yes _____ No _____ If yes, please explain below.

Does the applicant's current state of health prevent the applicant from practicing medicine safely? Yes _____ No _____
If yes, please explain in the space below. If additional space is needed, please include an attachment.

Attending Physician's Name

Telephone Number

Attending Physician's Address

City

State

Zip

I certify under the penalty of perjury under the laws of the State of California, that the information provided by the applicant is true and correct and that any information in supporting documents provided by the applicant is true and correct and that I am licensed to practice in the State of California.

Applicant's Signature

Date

Attending Physician's Signature

Date

License Number

CURRENT MAILING ADDRESS

☐ **Check here if this is a change of address** so that your record can be updated. If this is a U.S. Postal Service, P.O. box, you must list a confidential street address.

The Information Practices Act, Section 1798.17 Civil Code, requires the following information to be provided when collecting information from individuals. Agency Name: Medical Board of California, Licensing Program, 1426 Howe Avenue, Suite 54, Sacramento, CA 95825; Telephone: (916) 263-2344. The official responsible for information maintenance is the Chief. The authority, which authorizes the maintenance of the information, is the Business and Professions Code. Public Law 94-455(42 U.S.C.A. 405(c)(2)(C)) authorizes collection of your social security number (SSN) and/or federal employer identification number (FEIN). Your SSN and/or FEIN will be used exclusively for tax enforcement purposes and for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code. If you fail to disclose your SSN or FEIN, you will be reported to the Franchise Tax Board, which may assess a \$100 penalty against you. Failure to provide all or any part of the requested information will result in this form being rejected as incomplete. The principal purpose(s) for which the information is to be used is to determine your eligibility to restore your license to active status pursuant to Sections 704, 2439, 2440, 2441 and 2442 of the Business and Professions Code. Any known or foreseeable interagency or intergovernmental transfer, which may be made of the information, when necessary, is to other federal, state and local law enforcement agencies. Each individual has the right to review the files or records maintained on them by the agency, except for information, which is exempt from disclosure.